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This plan is offered in the State's Nashville & Memphis HMO Region. The counties in those regions are: Nashville: Cheatham, Davidson, Montgomery, Robertson, Rutherford, Sumner, Williamson and Wilson; and Memphis: Dyer, Fayette, Haywood, Lauderdale, Shelby and Tipton counties.

Introducing Aetna HMO

Thank you for considering this plan. This health care coverage is a Health Maintenance Organization (HMO) plan from Aetna Life Insurance Company (Aetna). This plan differs substantially from traditional health care protection coverage. It is important that you read this booklet carefully and become familiar with your health care program. You need to know how this HMO works in order to take full advantage of your health care program and avoid unnecessary costs. For instance, when you enroll in the HMO program you agree to receive all your care, except for emergency and urgently needed out-of-area care, through your Primary Care Physician (PCP). Also, benefits will not be paid if you receive care and have not chosen a PCP.

A printed directory of Aetna HMO health care providers is included in this enrollment packet. The updated network listing is also available to you on the Internet at **www.aetna.com**.

This medical benefit handbook will explain many features of the program. However it describes your benefits in general terms and is not intended to give all the details of every benefit, limitation, or exclusion described in the terms in your Group's Plan Document. The Plan Document is the official legal publication that defines benefits for this medical plan. If you have further questions, the assigned insurance preparer of your agency or workplace is also a good resource for information. For information about specific health care claims, please call the Member Services toll-free number on your ID card.

Member Services number:

1-877-719-3993

Our customer service representatives are familiar with your specific coverage and are available to answer your questions Monday through Friday from 8:00 a.m. to 6:00 p.m. EST.

Plan Administration and Claims Administration

The Division of Insurance Administration of the Department of Finance and Administration is the Plan administrator and Aetna is the claims administrator. This program is administered using the benefit structure established by the Insurance Committee that governs the Plan. When claims are paid under this Plan, they are paid from a fund consisting of your premiums and the Employer's contributions (if applicable) and not by an insurance company. Aetna is contracted by the State to process claims, establish and maintain adequate provider networks and conduct utilization management reviews in accordance with the plan of benefits outline in the Summary Schedule of Benefits.

Eligibility and Enrollment Topics

Please refer to your Employee Insurance Handbook available from your insurance preparer for all information related to eligibility and enrollment. Eligibility and enrollment are managed by the Plan Administrator, the Division of Insurance Administration of the Department of Finance

and Administration for the State of Tennessee.

How Is Incorrect Information Handled?

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. If your covered dependent(s) becomes ineligible, it is your responsibility to inform your Insurance Preparer and complete an Add/Change Enrollment Application within one full calendar month of that dependent's losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, even if you are under court order to continue to provide coverage. If there is any kind of error in your coverage or an error affecting the amount of your premium, it is your responsibility to notify your Insurance Preparer. Refunds of premiums are limited from the date a notice is received. Claims paid in error for any reason will be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting the Division of Insurance Administration at 1-800-253-9981.

Member Rights and Responsibilities

Aetna is committed to the prevention and treatment of diseases. To achieve this goal, certain member rights and responsibilities have been set. These promote quality medical services to our members. Each Member has the right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you choose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a covering physician 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **www.aetna.com/docfind**. Select DocFind Help. From the Help Menu, go

to Additional Information and select "Provider Compensation."
- Get up-to-date information about the services covered by the Plan - for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

Each Member is expected to:
- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your membership card to providers before getting care from them.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

13 Easy Guidelines for Using Your Benefits

1. Always **consult your PCP first** when you need medical care. If he or she deems it medically necessary, he or she will provide an electronic referral to a participating specialist or facility. **Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan.**
2. Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
3. Confirm the referral to the provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services.**
4. Certain services require ***both*** a referral from your PCP ***and*** prior authorization from Aetna.

5. If you have an emergency medical condition, seek help immediately at the nearest facility and contact your PCP as soon as possible.
6. If it is not an emergency and you go to another doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself.**
7. Always carry your HMO ID card. It lists copayment amounts, your ID number and your group number for identification.
8. Pay the copayments required by the Plan.
9. Call Member Services when you have questions. Dial toll-free:
   1-877-719-3993
   Monday through Friday 8:00 a.m. to 6:00 p.m. EST. Have your ID card available when calling.
10. Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.
11. Follow our Medical Services Reference Chart on page 30 of this handbook.
12. Remember that **if you change your Primary Care Physician, all referrals issued by your former Primary Care Physician are void**. Remind your new Primary Care Physician that you will need a new referral for any necessary specialty care.
13. You cannot request referrals ***after*** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) ***before*** seeking specialty or hospital care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. **To receive coverage for such services, you must have a prior written or electronic referral from your PCP for all non-emergency services and any necessary follow-up.**

The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Partnering with your PCP regarding your health care ensures non-duplication of services, appropriate utilization of medical resources, and provides for an objective, yet personal, overview of individual health care needs. Your Primary Care Physician also protects the confidentiality of your medical records.

It is important to remember that your HMO health plan provides coverage for specialist, hospital, and other medical care only when authorized by your PCP. Referrals to non-participating physicians must be approved by Aetna, in advance, otherwise, no benefit is available.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible only for the applicable copayment.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy for you to choose a PCP from Aetna's extensive network via the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, simply go to Aetna's Internet address: **www.aetna.com/docfind**. Choose either "Standard Search", "Search by Name", or "Find A Specialist".

Remember, you must select an Aetna HMO Primary Care Physician in order to be eligible for benefits under this plan. A change in Primary Care Physician voids all previous referral authorizations.

If Your Primary Care Physician Is Not Available

Aetna HMO Primary Care Physicians have 24-hours a day, 7 days a week coverage for all patients. If your own PCP is temporarily unavailable, the physician covering for your doctor is responsible for attending to your medical needs. Physicians designated by your personal PCP are the only Primary Care Physicians that are authorized for reimbursement for services you require in the absence of your doctor. These "covering physicians" can only be reimbursed in the absence of your doctor. Since your PCP, and not the "covering physician", knows your medical condition best, please confine visits to a "covering physician" to emergency or urgent situations and not routine care.

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **Except for those benefits described in this booklet as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.**

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the applicable copayment.

You should remind your PCP that you are an Aetna HMO member and you must be referred to a participating network specialist. Also inform the specialist physician's office that you have Aetna HMO coverage by showing a copy of your current HMO identification card. The participating specialist will bill Aetna directly for authorized services.

The referral, completed by your PCP is valid for a specific length of time or for a specific number of visits. Covered services are limited to those authorized by your PCP and covered by your health plan benefit package.

Except in an emergency, services cannot be authorized after they have occurred.

Remind your PCP that you are an Aetna HMO member and all referrals should be made within the Aetna HMO.

If you are currently under the care of a specialist physician, your Primary Care Physician will evaluate the need for continuing specialty care, and will refer you to an Aetna HMO specialist, if appropriate.

If the specialist determines that you should see another specialist or be admitted to a hospital, he or she should refer you back to your Primary Care Physician to make those arrangements. Please remind your specialist that you are an Aetna HMO member and that you should be referred back to your PCP in this situation.

Remember, to receive benefits under this plan your care must be provided by or authorized by your PCP through the referral process. Referrals will be made to network (participating) providers. If no network provider is available, your PCP will request an approval for an out-of-network non-standard referral This must be done before services are rendered. When approved, these "non-standard" referrals are also covered.

Some PCPs are affiliated with integrated delivery systems or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the integrated delivery system or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Referral Quick Facts

- Your PCP must submit referral requests to Aetna HMO.
- Referrals to specialists must be obtained before services are rendered.
- Referrals to out-of-network providers must be approved by Aetna before services are rendered. Approvals are made for medical necessity purposes only, not for convenience.
- There will be no payment for services not covered by this plan, even if there is a valid referral. Please refer to the list of common non-covered services on page 22 of this handbook.

Specialist as Principal Physician Direct Access Program

If you have a serious or complex medical condition, you may need ongoing specialty care. A "serious or complex medical condition" is generally a life-threatening, degenerative or disabling condition or disease such as AIDS, cancer, emphysema, an organ failure that may require a transplant or diabetes with target organ involvement.

The Specialist as Principal Physician Direct Access Program is a voluntary program. Eligibility is based upon the nature of your

medical condition, your need for continuing specialty care and a specialist's willingness to serve as your principal physician for treatment of the condition. Enrollment in the program must be approved by Aetna. Once you are enrolled, a case manager will be available to answer questions about the features of the program, to assist with any necessary authorizations or precertifications, and to facilitate communications between your PCP and the specialist treating your condition.

If you are interested in enrolling in the Specialist as Principal Physician Direct Access Program, contact Member Services at the toll-free number shown on your ID card and ask to be transferred to a disease management representative.

These "direct access" services do not require a referral:

- Routine Gynecological Exams (includes routine GYN exam and Pap smear)*****
- Basic infertility services to diagnose the underlying medical cause of infertility*****
- Routine Eye Examinations*****
- Emergency Care

* **These services must be performed by Aetna-HMO participating facility/provider.)**

Direct Access Covered Services

Direct Access Gynecology Program

This program allows a female Plan participant to visit any participating gynecologist for routine well-woman exams, including a Pap smear when appropriate, and an unlimited number of visits for gynecological problems and follow-up care, without a referral from her PCP. Participating gynecologists may also refer a woman directly for appropriate gynecological services without the patient's having to go back to her participating PCP.

If your gynecologist is affiliated with an integrated delivery system or provider group (such as an Independent Practice Association), you may be required to access your care through that integrated delivery system or provider group.

Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

If you need emergency care, seek treatment at the nearest medical facility. Contact your Primary Care Physician (PCP) first, if possible. After assessing and stabilizing your condition, the emergency facility should contact your PCP regarding your medical history. If you are admitted to an inpatient facility, notify your PCP. Your PCP will make arrangements for your follow-up care.

Follow-Up Care After Emergencies

All follow-up care should be accessed through your PCP. You must have a referral from your PCP ***and*** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Follow-up care provided by your PCP is fully covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP**.**

An urgent medical condition is a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP. See page 38 for information on Urgent Care treatment obtained in your service area.

Examples of emergency situations are:
- heart attack or suspected heart attack
- poisoning
- severe shortness of breath
- uncontrolled or severe bleeding
- suspected overdose of medication
- severe burns
- high fever (especially in infants)
- loss of consciousness

Examples of urgent care situations are:
- severe vomiting
- earaches
- sore throat
- fever

Use of the Emergency Room

The emergency room should be used only in an emergency care or urgent care situation when referred by your Primary Care Physician. Use of the emergency room in a non-emergency situation without a referral is not covered. Please call your Primary Care Physician before receiving emergency room treatment whenever possible. Often your Primary Care Physician will be able to give you the necessary care in his or her office, or can give you the appropriate instructions for treatment. For each covered emergency room

visit, you will pay the emergency room copayment listed on your ID card. Make sure to show your ID card to the hospital when you receive medical care. If you are admitted, the emergency room copayment will be waived.

Examples of routine problems which are not covered in the emergency room are:

- recurring headaches
- persistent cold symptoms
- minor aches and pains
- minor infections
- mild fever
- requests for exams or immunizations
- chronic or recurring problems such as back pain

based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Prior authorization is not a confirmation of benefits. Actual benefits are provided based upon eligibility of the member as well as all terms, conditions, limitations and exclusions of the benefit plan.

Special rules apply to Mental Health and Substance Abuse hospitalizations. Please see page 17 of this handbook for details.

Prior Authorization (Pre-Certification)

Prior authorization (pre-certification) is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with medical needs of the member and with patterns of care of an established managed care environment for treatment of a particular illness, injury or medical condition.

Prior authorization is required for certain services including but not limited to inpatient hospitalization, private duty nursing and out-of-network treatment.

The PCP, or approved specialist, should request these prior authorizations.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition,

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a Member Services representative can take this information over the telephone.

HMO Benefits

Your Benefits

All medical treatment begins with your PCP, who will help you understand your health care options and refer you to specialists and other facilities when medically necessary. Except in certain emergencies (see "In Case of Emergency"), always consult your PCP first when seeking medical treatment.

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition.

You should call Member Services:
1-877-719-3993
Monday through Friday, 8:00 a.m. to 6:00 p.m. EST if you have any questions regarding covered benefits.

Primary and Preventive Care

The following types of benefits are available through your participating PCP when medically necessary. Please consult your PCP for any possible benefit limitations.

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- One prostate screening per calendar year, including prostate specific antigen (PSA) test and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- One routine gynecological examination and Pap smear performed within the calendar year by your PCP or participating gynecologist.
- The Plan provides coverage for mammogram screenings with the following guidelines: (1) once as a baseline mammogram for ages 35-39; (2) once every calendar year for ages 40 and over; or (3) when prescribed by a Physician. Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Periodic eye examinations. You may visit a participating provider without a referral as follows:
  If you wear eyeglasses or contact lenses:
  - age 1-18 years - one exam every 12 months.
  - age 19 or over - one exam every 24 months.
  If you do not wear eyeglasses or contact lenses:
  - age 1-44 years - one exam every 36 months.
  - age 45 or over - one exam every 24 months.
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling) and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury. Limited benefits apply.
- Short-term cardiac rehabilitation provided on an outpatient basis when medically necessary following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis when medically necessary for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "Emergency Care").
- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided by, or supervised by, an RN.
  - services of a home health aide for skilled care.
  - medical social services provided by, or supervised by, a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

  Note: The Plan does ***not*** cover:
  - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling. Free counseling and referral services may be available through the State's Employee Assistance Program. Call the Employee Assistance Program at **1-877-237-8574** to see if you are eligible for these services.
  - homemaker or caretaker services, and any service not solely related to the care of the terminally ill patient.
  - respite care when the patient's family or usual caretaker cannot, or will not, attend to his or her needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, and removal of tumors and orthodontogenic cysts); treatment of accidental injury (other than by eating or chewing) to sound natural teeth including their replacement (within certain limitations) provided the accident occurred while the participant was covered by a State sponsored medical plan.
- Reconstructive breast surgery following a mastectomy, including:

- reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
- surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
- medically necessary physical therapy to treat the complications of the mastectomy, including lymphedema.

- Infertility services to diagnose the underlying medical cause of infertility. You may obtain the following **basic** infertility services from a participating gynecologist or infertility specialist ***without*** a referral from your PCP:
  - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
  - evaluation of ovulatory function,
  - ultrasound of ovaries at an appropriate participating radiology facility,
  - postcoital test,
  - hysterosalpingogram,
  - endometrial biopsy, and
  - hysteroscopy.

  Semen analysis at an appropriate participating laboratory is covered for male members; a referral from your PCP is necessary.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth) when approved by Aetna.
- Rental or initial purchase (or necessary repair) of durable medical equipment prescribed by a physician for the treatment of an illness or injury. Changes made to your home, automobile or personal property, such as air conditioning or remodeling, are not covered. Rental coverage is limited to the purchase price of the durable medical equipment. Replacement, repair and maintenance are covered only if:
  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

  The request for any type of durable medical equipment must be made by your physician and coordinated through Aetna's Patient Management Department.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below, as medically necessary. See "Mental Health/Substance Abuse" for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill and a prognosis of less than 6 months to live.
- Intensive or special care facilities when medically necessary.
- Visits by your PCP or specialist while you are confined.
- General nursing care.
- Private-duty nursing when medically necessary and certified by your specialist, in agreement with your PCP, and approved in advance by Aetna.
- Surgical, medical and obstetrical services provided by the participating hospital.

- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications when necessary.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations.
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic Resonance Imaging (MRI).
- Non-experimental, non-investigational transplants. All transplants must be ordered by your PCP and participating specialist, and approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may - **after consulting with you** - discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found on DocFind (see pages 6-7).

> **Note**: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. He or she must request approval (precertification) for any tests performed outside of his or her office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Mental Health/Substance Abuse

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call Magellan Behavioral Health at **1-800-723-5845,** 24 hours a day, 7 days a week. Member Services will put you in contact with the behavioral health vendor, and you can speak with a clinical care manager who will assess your situation and refer you to participating providers, as needed.

Treatment of Mental or Nervous Conditions

The Plan covers the following services for mental health treatment:

- Inpatient medical, nursing, counseling and therapeutic services in a non-hospital residential facility, appropriately licensed.
- Short-term evaluation and crisis intervention mental health services provided on an outpatient basis.

Treatment of Alcohol and Drug Abuse

The Plan covers the following services for treatment of alcohol and drug abuse:

- **Inpatient** care for detoxification, including medical treatment and referral services for substance abuse or addiction.
- **Inpatient** medical, nursing, counseling and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an appropriately licensed facility.
- **Outpatient** visits for substance abuse detoxification. Benefits include diagnosis, medical treatment and medical referral services by your PCP.
- **Outpatient** visits to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for substance abuse. Outpatient treatment for substance abuse or dependency must be provided in accordance with an individualized treatment plan.

Pharmacy Benefits

The Plan pays, subject to any limitations specified under "Your Benefits," the cost incurred for outpatient prescription drugs that are obtained from a participating pharmacy. You must present your ID card and make the copayment shown in the "Summary Schedule of Benefits" for each prescription at the time the prescription is dispensed.

The Plan covers charges for prescription drugs, in excess of the copayment, which are:

- Medically necessary for the care and treatment of an illness or injury, as determined by Aetna;
- Prescribed in writing by a physician who is licensed to prescribe federal legend prescription drugs or medicines; and
- Not listed under "Prescription Drug Exclusions and Limitations," below.

Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (but not to exceed one year from the date originally prescribed). Non-emergency prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name products.

Coverage is based upon Aetna's Formulary. The Formulary includes both brand-name and generic drugs and is designed to provide access to quality, affordable outpatient prescription drug benefits. You can reduce your copayment by using a covered generic or brand-name drug that appears on the formulary. Your copayment will be highest if your physician prescribes a covered drug that does not appear on the formulary.

Aetna Rx Home Delivery℠

Participants in the Plan who must take a medication regularly or daily to treat a chronic condition such as arthritis, diabetes or heart disease, Aetna Rx Home Delivery program offers an easy way to obtain them through the mail. These medications are delivered right to your door.

You may obtain up 90-day supply of the drug through Aetna Rx Home Delivery, if authorized by your physician.

The minimum quantity dispensed through the program is for a 31-day supply, and the maximum quantity is for a 90-day supply.

The copayment shown in the "Summary Schedule of Benefits" will apply to each home delivery purchase.

For a new prescription, you must fill out an order form. You can download an order form at **www.aetnarxhomedelivery.com**. Or you can call **1-866-612-3862** to request a form. See page 41 for more information.

Prescriptions for medications to treat an acute condition, such as infection, should be filled at your local retail participating pharmacy.

Step-Therapy Program

Certain drugs are excluded by the Plan, unless you have already tried one or more "prerequisite therapy" drugs. However, if it is medically necessary for you to be treated initially with a step-therapy medication, your physician can contact Aetna to request coverage as a medical exception. If the request is approved, the drug will be covered. The drugs requiring step-therapy are subject to change. Please call Member Services at **1-877-719-3993** Monday through Friday 8:00 a.m. to 6:00 p.m. EST, or visit the Aetna web site at **www.aetna.com** for the current Step-Therapy List.

Precertification

Your pharmacy benefits plan includes Aetna's precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by Aetna's Pharmacy Management Precertification Unit before they will be covered. Only your physician can request prior authorization for a drug.

The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's Formulary.

The drugs requiring precertification are subject to change. Call Member Services at **1-877-719-3993** Monday through Friday 8:00 a.m. to 6:00 p.m. EST, or visit the Aetna web site at **www.aetna.com** for the current Precertification List.

Emergency Prescriptions

You may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are travelling outside of the Plan's service area. If you must have a prescription filled in such a situation, the Plan will reimburse you as follows:

Non-Participating Pharmacy

Coverage for items obtained from a non-participating pharmacy is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are responsible for submitting a written request for reimbursement to Aetna, accompanied by the receipt for the prescription. Aetna will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost, minus any applicable copayment.

Participating Pharmacy

When you obtain an emergency or urgent care prescription at a participating pharmacy (including an out-of-area participating pharmacy), you must pay the copay. Aetna will not reimburse you if you submit a claim for a prescription obtained at a participating pharmacy.

Covered Drugs

The Plan covers the following:

- Outpatient prescription drugs when prescribed by a provider who is licensed to prescribe federal legend drugs or medicines, subject to the terms, limitations and exclusions described in this booklet.
- FDA-approved prescription drugs when the off-label use of the drug has not been approved by the FDA to treat the condition in question, provided that:
  - the drug is recognized for treatment of the condition in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or
  - the safety and effectiveness of use for the condition has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.
- Diabetic supplies, as follows:
  - diabetic needles and syringes.
  - alcohol swabs.
  - test strips for glucose monitoring and/or visual reading.
  - diabetic test agents.
  - lancets (and lancing devices).
- Contraceptives and contraceptive devices, as follows:
  - oral contraceptives.
  - one diaphragm per 365-day period.
  - up to 5 vials of Depo-Provera in a 365 consecutive-day period. A separate copayment applies to each vial.
  - Norplant and IUDs are covered when obtained from your PCP or participating Ob/Gyn. The office visit copayment will apply when the device is inserted and removed.

Prescription Drug Benefit Levels and Limitations

There is a $40 copay for brand-name non-formulary prescription drugs, a $20 copay for brand-name formulary prescription drugs or a $5 copay for generic prescriptions. You may purchase up to a 30 day supply of prescription drugs from a participating retail pharmacy for one copayment, or you may purchase up to a 90 day supply through Aetna Rx Home Delivery for one copayment. If no generic is available, the brand-name copay is still applicable. If the cost is less than the copay, then you will pay the lesser amount.

The following services and supplies are not covered by the Plan and a medical exception is not available for coverage:

- Any drug that does not, by federal or state law, require a prescription order, even when a prescription is written.
- Any drug that is not medically necessary.
- Prescription drugs purchased prior to the effective date, or after the termination date, of coverage this Plan.
- Replacement of lost or stolen prescriptions.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Drugs labeled "Caution - Limited by Federal Law to Investigational Use" and experimental drugs, even though a charge is made to the individual.
- Drugs prescribed for uses other than the uses approved by the Food and Drug Administration (FDA) under the Food, Drug, and Cosmetic Law and regulations.
- Any prescription for which the actual charge to you is less than the copayment.
- Any prescription for which no charge is made to you.

- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth, including (but not limited to):
  - Loniten (Minoxidil).
  - Retin A for wrinkles.
  - Health and beauty aids.
- Medication which is to be taken by you or administered to you, in whole or part, while you are a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital or nursing home.
- Take-home prescriptions dispensed from a hospital pharmacy upon discharge, unless the hospital pharmacy is a participating retail pharmacy.
- Any medication that is consumed or administered at the place where it is dispensed.
- Medical and non-medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use.
- Immunization or immunological agents, including:
  - biological sera.
  - allergy sera and testing materials.
- Injectable drugs, except insulin and injectable contraceptives. The plan does not cover injectable drugs used in the treatment of infertility.
- Needles and syringes, except diabetic needles and syringes.
- Test agents and devices, except diabetic test strips.
- Insulin pumps or tubing for insulin pumps.
- Drugs used in the treatment of infertility.
- Drugs used for the purpose of weight reduction, including the treatment of obesity.
- Charges for the administration or injection of any drug. See "Primary and Preventive Care" for more information.
- Drugs used to aid or enhance sexual performance, including (but not limited to):
  - Sildenafil citrate (e.g. Viagra), phentolamine, apomorphine and alprostadil in oral, injectable, and topical (including but not limited to gels, creams, ointments and patches) forms, and
  - any prescription drug in oral, topical, or any other form that is in a similar or identical class, has a similar or identical mode of action, or exhibits similar or identical outcomes, unless otherwise covered under this plan.
- Performance, athletic performance, or lifestyle-enhancement drugs and supplies.
- Smoking-cessation aids or drugs.
- Growth Hormones.

Over-the-counter purchases are not eligible expenses unless they require pharmacist preparation.

Prescription Drug Limitations

The following limitations apply to the prescription drug coverage:

- A participating retail pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
- Prescriptions may be filled only at a participating retail pharmacy, except in the event of emergency or urgent care. Plan participants will not be reimbursed for out-of-pocket prescription purchases from either a participating or non-participating pharmacy in non-emergency, non-urgent care situations.
- The Plan is not responsible for the cost of any prescription for which the actual charge to you is less than the copayment, or for any prescription for which no charge is made to you.
- Plan participants must present their ID cards at the time each prescription is filled to verify coverage. If you do not present your ID card, your purchase may not be

covered by the Plan, except in emergency and urgent care situations, and you may be required to pay the entire cost of the prescription.

Non-Covered/Excluded Services and Procedures

Exclusions

Any expense or procedure that is not determined to be medically necessary by Aetna will not be covered. The Plan does not cover the following services and supplies:

1. Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
2. Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
3. Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
4. Any services or supplies that are not medically necessary, as determined by Aetna.
5. Biofeedback, except as specifically approved by Aetna for certain conditions.
6. Breast augmentation and otoplasties, including treatment of gynecomastia, except when approved in advance by Aetna. Reduction mammoplasty is not covered unless medically necessary, as determined by Aetna.
7. Canceled office visits or missed appointments.
8. Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
9. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
10. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
    - reconstructive surgery to correct the results of an injury.
    - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
    - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
11. Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
12. Custodial care and rest cures.
13. Dental care and treatment, including (but not limited to):
    - care, filling, removal or replacement of teeth,
    - dental services related to the gums,
    - apicoectomy (dental root resection),
    - orthodontics,
    - root canal treatment,
    - soft tissue impactions,
    - alveolectomy, augmentation and vestibuloplasty
    - treatment of periodontal disease,
    - prosthetic restoration of dental implants, and dental implants.

    However, the Plan does cover oral surgery as described under "Your Benefits."
14. Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and

developmental delays are not covered by the Plan.

15. Expenses that are the legal responsibility of Medicare or a third party payer.
16. Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance. This exclusion will not apply to drugs:
    - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
    - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
    -that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.
17. False teeth.
18. Hair analysis.
19. Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
20. Hearing aids or the fitting thereof.
21. Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
22. Hypnotherapy, except when approved in advance by Aetna.
23. Immunizations related to travel or work.
24. Implantable drugs (except as described under "Pharmacy Benefits").
25. Infertility services, except as described under "Your Benefits." The Plan does not cover:
    - purchase of donor sperm and any charges for the storage of sperm.
    - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
    - cryopreservation and storage of cryopreserved embryos.
    - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
    - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
    - injectable infertility drugs.
    - the costs for home ovulation prediction kits.
    - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
    - services for females with FSH levels greater than 19 mIU/ml on day 3 of the menstrual cycle.
26. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
27. Orthotics.
28. Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
29. Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
30. Private duty or special nursing care, unless pre-authorized by Aetna.

31. Radial keratotomy, including related procedures designed to surgically correct refractive errors as well as LASIK surgery and related procedures.
32. Religious, marital and sex counseling, including related services and treatment.
33. Reversal of voluntary sterilizations, including related follow-up care.
34. Routine hand and foot care services, including routine reduction of nails, calluses and corns.
35. Services not covered by the Plan, even when your PCP has issued a referral for those services.
36. Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
37. Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
38. Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
    - obtaining or continuing employment,
    - obtaining or maintaining any license issued by a municipality, state or federal government,
    - securing insurance coverage,
    - travel, and
    - school admissions or attendance,

    including examinations required to participate in athletics,
    unless the service is considered to be part of an appropriate schedule of wellness services.
39. Services that are not medically necessary.
40. Services you are not legally obligated to pay for in the absence of this coverage.
41. Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
42. Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
43. Specific injectable drugs, including:
    - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH),
    - needles, syringes and other injectable aids (except as described under "Pharmacy Benefits"),
    - drugs related to treatments not covered by the Plan, and
    - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
44. Specific non-standard allergy services and supplies, including (but not limited to):
    - skin titration (wrinkle method),
    - cytotoxicity testing (Bryan's Test),
    - treatment of non-specific candida sensitivity, and
    - urine autoinjections.
45. Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
46. Therapy or rehabilitation, including (but not limited to):
    - primal therapy,
    - chelation therapy,
    - Rolfing,
    - psychodrama,
    - megavitamin therapy,
    - purging,
    - bioenergetic therapy,
    - vision perception training, and
    - carbon dioxide therapy.
47. Thermograms and thermography.
48. Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from his or her biologically determined sex to

those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

49. Treatment in a federal, state or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
50. Treatment of injuries sustained while committing a felony.
51. Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
52. Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
53. Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
54. Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
55. Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
56. Non-surgical treatment of temporomandibular joint (TMJ) syndrome, including but not limited to, treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutic services related to TMJ.
57. Weight reduction programs and dietary supplements.
58. Wigs or hairpieces.
59. Ear or body piercing.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

What If I'm Not Sure Whether a Service Is Covered?

If you are unsure about whether a procedure, type of facility, equipment or any other expense is covered under this medical plan, ask your physician or call Member Services at **1-877-719-3993**, Monday through Friday from 8:00 a.m. to 6:00 p.m. EST.

Special Benefits

Moms-to-Babies Maternity Management Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Assistance in accessing prenatal care.
- Case management by registered nurses, who will assist in arranging covered services, arrange for covered specialty care, review the program's features and answer general pregnancy-related questions.
- Smoke-free Moms-to-be™, a personalized stop-smoking program

designed specifically for pregnant women.
- Focused, educational information, "For Dad or Partner."
- A comprehensive pregnancy handbook.

Under the program, all care during your pregnancy is accessed through your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

For more information, call
1-800-CRADLE-1 (1-800-272-3531.)
Monday through Friday 8:00 a.m. to 5:00 p.m. EST.

Coordination of Benefits With Other Plans

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" automobile reparations insurance required by law, and provided on other than a group basis (but only to the extent of the level of benefits required by the no-fault law).

To find out if benefits under the Plan will be coordinated, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

1. The plan without a coordination of benefits provision determines its benefits before the plan that has such a provision.

2. The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under these rules, the order of benefits will be determined as follows:

    - The plan that covers the person as a dependent of a working spouse will pay first;
    - Medicare will pay second; and
    - The plan that covers the person as a retired employee will pay third.

3. Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's coordination of benefits rule applies.

4. When the parents of a dependent child are divorced or separated:

- If there is a court decree which states that the parents will share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in No. 3, immediately above, apply.
- If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
- If there is no such court decree, the order of benefits will be determined as follows:
  - the plan of the stepparent with whom the child resides,
  - the plan of the natural parent with whom the child does not reside, or
  - the plan of the stepparent with whom the child does not reside.

5. If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.

6. The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.

7. If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

"Allowable expenses" are the necessary and reasonable health expenses covered (in whole or in part) under any of your plan(s) (or those of the person for whom you make a claim).

If it is determined that the other plan pays first, the benefits under the Plan will be coordinated.

Aetna will calculate this coordinated amount as follows:

- 100 percent of allowable expenses,

Less

- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Right of Recovery (Subrogation)

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) lawsuit settlement from payments made from any source. This would include automobile or homeowners insurance, whether yours or another's. You are required to assist in this process and should not settle any claim without written consent from Aetna. For further information contact Aetna's Member Services department by calling:

1-877-719-3993

Monday through Friday 8:00 a.m. to 6:00 p.m. EST.

Appeals Procedures

Your Right to Appeal a Denied Claim

If you are in disagreement with a decision or the way a claim has been paid or processed,

you should first call Aetna at **1-877-719-3993**, Monday through Friday, 7:30 a.m. to 5:00 p.m. EST, and speak to a Customer Service Professional. If you are unable to resolve your contention, you can write to the Appeals Coordinator at:

Aetna
P.O. Box 14463
Lexington, KY 40512

Once your written appeal is received by the Appeals Coordinator, Aetna will send you an acknowledgement letter informing you of the procedures governing appeals.

External Review

If the appeal is unresolved through the Aetna Appeals Procedures, you should request a review through the Aetna External Review option where applicable, prior to initiating the second level appeal with the Division of Insurance Administration.

An external review is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials and denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment. You may request a review by an external review organization if:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, and will include a copy of the Request for External Review Form. If you choose not to elect the external review, you can appeal the final claim denial directly to the Plan Administrator, as outlined in "Appeals Procedures."

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. The form must be accompanied by a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the Request for External Review Form, and will follow the applicable plan's contractual documents and plan criteria governing the benefits. You will generally be notified of the decision of the External Review Organization within 30 days of Aetna's receipt of your request form and all necessary information. An expedited review is available if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would jeopardize your health. Expedited reviews are decided within 3-5 calendar days after Aetna receives the request.

The decision of the External Review Organization will be taken into consideration by the Plan Administrator in making a final decision on coverage.
You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization.

Second Level of Appeal

If your appeal is not resolved through the Aetna Appeals Procedure or through Aetna External Review Program where applicable (outlined above), you can initiate a second level appeal by sending a letter to the Division of Insurance Administration, Attention: Appeals Coordinator 13th Floor, William R. Snodgrass Tennessee Tower, 312 Eighth Avenue North, Nashville, TN 37243 with details of the events leading up to the point of disagreement. The Appeals Coordinator can also be reached by calling 615-741-3590 or 1-800-253-9981, 7:30 a.m. to 4:00 p.m. CST, Monday through Friday. All documented information including the Explanation of Benefits, physician statements, name of Aetna personnel and dates spoken with, as well as any other correspondence related to the appeal should be sent with the letter.

The Appeals Coordinator in the Division of Insurance Administration will thoroughly review all information to determine the exact nature of the appeal. The majority of requests for appeals require additional review by Aetna. The average review takes approximately 30 days to complete. Cases requiring additional medical information may be extended depending on the circumstances. Some cases may also require a review by the State's independent medical consultant.

The Insurance Appeals Staff Review Committee is the first level of appeal with the State. Employees will have the option of personally appearing before this Committee, or the appeal can be reviewed based on the written record.

Final Appeal

After the Insurance Appeals Staff Review Committee has heard the appeal, their decision will be reported to the Appeals Subcommittee of the State Insurance Committee. The Appeals Subcommittee is the second level of appeal. This Committee will either agree with the Insurance Appeals Staff Review Committee's vote on the appeal or review the appeal themselves. If they agree, the action of the Insurance Appeals Review Committee will stand. If an appeal is denied, any additional appeal options available will be explained in the decision notification letter.

Administrative Appeal

To file an appeal regarding an administrative process or decision (e.g., special enrollment provisions, transferring between health plans, or effective dates of coverage issues), contact your insurance preparer indicating the circumstances of your appeal.

We Want You To Be Satisfied

We want you to be satisfied with this HMO plan. If you have a question or concern about your health plan, we want to resolve it as quickly as possible. Our Member Services department is ready to help you. Our representatives will gladly assist you in every way to meet this goal. You can reach our Member Services department by calling:

1-877-719-3993

Monday through Friday 8:00 a.m. to 6:00 p.m. EST.

Medical Services Reference Chart

The information below is to be used as a guideline only. It does not supersede the terms contained in your Summary of Benefits.

Non-emergency or Routine problems	**Example** • Persistent cold/flu symptoms • Minor aches and pains • Minor fever • Chronic back pain • Request for exams, or immunizations or preventive screening (e.g. mammogram)	**Contact** Your Primary Care Physician (PCP).	**Result** PCP will establish an appointment and/or provide advice or instruction.
Urgent medical problems	• Severe vomiting • Earaches • Sore throat • Fever	Your Primary Care Physician (PCP).	PCP will establish an appointment and/or provide advice or instruction.
Emergency medical problems	• Heart attack or suspected heart attack • Poisoning • Severe shortness of breath • Uncontrolled or severe bleeding • Suspected overdose of medication • Severe burns • High fever (especially in infants) • Loss of consciousness	If any delay threatens life or limb, receive emergency services immediately. If able, contact your PCP first, then go to the closest emergency facility.	Have medical facility, family member or yourself, if able, contact your PCP as soon as possible.
Hospitalization/Out patient surgery (includes invasive procedures)	• Surgery, general hospital • Medical treatment • Surgery, free standing medical facility	Your Primary Care Physician (PCP).	PCP will provide service, admission, and/or referral specialist.
Diagnostic	• Lab • X-ray • Other diagnostic tests	Your Primary Care Physician (PCP).	PCP will determine test, provide test, or refer you to other appropriate facility or specialist
EAP/Mental Health/Substance Abuse	• Psychological problems • Drug or alcohol dependency	Magellan Behavioral Health: Call 1-800-723-5845 EAP: Call 1-877-237-8574	Magellan or your EAP Care manager will refer you to appropriate provider when necessary.
Female Health Care	**Example** • Routine Gynecological Exams • Pap smears • Tests • Pregnancy • Pregnancy delivery	**Contact** Your Primary Care Physician (PCP) or a participating OB/GYN specialist.	**Result** PCP or a participating OB/GYN will provide many routine services or refer you to another specialist if necessary. An annual visit to a
Allergy	• Allergy testing • Allergy immunization therapy	Your Primary Care Physician (PCP)	PCP will provide services or refer you to appropriate specialist if necessary.

HMO
Summary Schedule of Benefits
Important Information: Please Read This Section Carefully

Introducing Aetna HMO

All services must be provided or authorized by a participating Aetna network physician.

Service	Copayment
OUTPATIENT SERVICES	
Primary Care Physician (PCP) office visits	$15 copay per visit
Specialist Physician office visits	$20 copay per visit
X-ray, laboratory and diagnostic services	No copay
Routine allergy injections administered by PCP/Specialist	$15/$20 copay per visit
Routine allergy injections administered by nurse or nurse practitioner	No copay
PREVENTIVE HEALTH SERVICES/WELL CARE	
Well-child care from birth, including immunizations and booster doses; routine physical exams; routine hearing and periodic eye exams.	$15 copay per visit
INPATIENT SERVICES	
Physician services including consultations, readings, surgical procedures and anesthesia.	No copay
Hospital services including semi-private room and board, operating room, intensive care, x-ray, laboratory, drugs and supplies.	$100 copay per admission
*If readmitted within 48 hours for the same condition	No copay
SKILLED NURSING (CONVALESCENT) FACILITIES	
Confinement in semi-private accommodations in an extended care/skilled nursing facility (in lieu of hospital confinement).	No copay per admission
MATERNITY CARE	
Outpatient physician care (prenatal care)	$20 copay for the first OB visit only
Inpatient (including nursery charges)	$100 copay per admission
MENTAL HEALTH CARE	
Outpatient: 45 visits per calendar year (outpatient care limit is for mental health/substance abuse combined.)	$20 copay per visit
Inpatient: 30 days inpatient care per calendar year (a day care program is considered to be one-half day for purposes of this limitation.)	$100 copay per admission

Service	Copayment
SUBSTANCE ABUSE Outpatient: 45 visit per calendar year (outpatient care limit is for substance abuse/mental health combined.)	$20 copay per visit
Inpatient: 30 days inpatient care per calendar year (a day care program is considered to be one-half day for purposes of this limitation.) 1. Lifetime maximum: One (1) Inpatient stay, maximum of 28 days. 2. Lifetime maximum: Two (2) stays for detoxification, maximum of 5 days per stay. • The pre-authorization process must be followed for all mental health/substance abuse benefits to be payable. No benefits are payable if services are not pre-authorized. • Expenses determined not be medically necessary by the Medical Management Review will not be covered. • Intermediate Care (halfway houses, residential treatment facilities, partial hospitalization) will be treated as one-half inpatient day subject to the HMO Plan total of applicable days.	$100 copay per admission
THERAPY Speech, occupational or physical therapy. Limited to 45 calendar days per illness or injury per year.	$15 copay per visit
AMBULANCE SERVICE If medically necessary and approved or authorized by a participating physician. (Air or ground transportation)	No copay
APPLIANCES AND EQUIPMENT (DURABLE MEDICAL EQUIPMENT) Durable Medical Equipment and Prosthetic Devices: Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth); rental or initial purchase (or necessary repair) of durable medical equipment prescribed by a physician for the treatment of an illness or injury. The request for any type of durable medical equipment must be made by your physician and coordinated through Aetna's Patient Management Department.	No copay – must be approved in advance by Aetna
CHIROPRACTIC CARE	Not a covered benefit

Service	Copayment
PRESCRIPTION DRUGS 30 day supply (Retail) 90 day supply (Aetna Rx Home Delivery) Outpatient prescription drugs prescribed in writing by a physician, filled at a Participating Pharmacy (if non-emergency). Each prescription is limited to a maximum 30-day supply, with refills as authorized by your physician (not to exceed one year from the date originally prescribed.) Generic drugs may be substituted for brand-name products. Coverage is based upon Aetna's Formulary, which includes both brand-name and generic drugs. If your physician prescribes a medication that is on the Formulary Exclusions list, it will not be covered unless your physician obtains a medical exception from Aetna. Participants in the Plan who must take a drug for more than 30 days may obtain up to a 90-day supply of the drug through the Aetna Rx Home Delivery℠ program, if authorized by their physician. The minimum quantity dispensed by Aetna Rx Home Delivery℠ is for a 31-day supply, and the maximum quantity is for a 90-day supply. For a complete description of the prescription drug program, including the new Aetna Rx Home Delivery℠ program, see pages beginning on 18 and 40. **Formulary is subject to modification periodically as new drugs become available and are evaluated by the Aetna Pharmacy Management Unit.**	\$5 copay generic \$20 copay brand-name formulary \$40 copay brand-name non-formulary
EMERGENCY CARE Emergency Room Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care. 1. Call your PCP first, if possible. Your PCP is required to provide emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial 911 (if your area has this emergency response service). 2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so he or she can assist the treating physician by supplying information about your medical history. 3. If you are admitted to an inpatient facility, notify your PCP as soon as possible. The emergency room copayment will be waived if you are admitted to the hospital. 4. All follow-up care must be accessed by your PCP.	\$50 copay, waived if admitted

Vision One® Discount Program

Plan participants are eligible to receive discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the Vision One program at thousands of locations nationwide. Just call 1-800-793-8616 for information and the location nearest you.

Vision One is a registered trademark of Cole Vision.

Frequently Asked Questions

The following are designed to help answer the most common questions asked by our Plan Members**.** If you have questions not answered here, please call our Member Services Department at **1-877-719-3993**, Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

YOUR PHYSICIAN

Q: Do I need to select a physician when I enroll in the plan?

A: Yes. You must select a PCP before you can enroll in the Aetna HMO Plan. Benefits will not be paid if you receive care and have not chosen a PCP.

It is easy for you to choose a PCP from Aetna's extensive network via the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, simply go to Aetna's Internet address: **www.aetna.com/docfind**. Select the appropriate provider category and follow the instructions provided to select a PCP based on geographic location and/or hospital affiliation.

Q: What kind of Physicians are Primary Care Physicians?

A: These Physicians are Internists, Family Practitioners, General Practitioners and Pediatricians.

Q: Why is my Primary Care Physician so important?

A: Your Primary Care Physician will be responsible for taking care of most of your medical needs and should be your **first** contact (24 hours a day, 7 days a week). They will help you maintain good health through periodic health evaluations and preventive health services. (In the case of an emergency; see the Emergency Care section.)

Q: When should I meet my Primary Care Physician?

A: You are encouraged to schedule a get-acquainted appointment with your Primary Care Physician to discuss your medical

history and ask questions about anything you do not understand. It is important to let the Physician's office know this will be your first appointment so they can schedule more time. When you need medical services, your Primary Care Physician will know your history and it will be easier for him/her to make a diagnosis. If, at any time, you or your covered dependents/family members wish to change Primary Care Physicians, you can call Member Services at:

1-877-719-3993

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST, or you can access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**.

Q: How do I change my Primary Care Physician?

A: You may change your Primary Care Physician by calling Member Services at:

1-877-719-3993

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST, or access Aetna Navigator™ through the Aetna Internet website home page or directly via **www.aetnanavigator.com**.

You will then be issued new ID cards. It is important that the tax ID number of your Primary Care Physician appear on your new card. If it does not appear, call the Member Services Department.

Q: Can female Aetna HMO Members receive Obstetrical-Gynecological (OB/GYN) care? Does the Primary Care Physician have to be contacted first?

A: Female Aetna HMO Members and their eligible female dependents/ family members may go to an Obstetrician or Gynecologist within the Primary Care Physician network. A referral from the original Primary Care Physician is not necessary. It is important to tell your Primary Care Physician about any care received from an Obstetrician/Gynecologist.

The yearly well-woman examination is limited to an annual breast exam, Pap smear and pelvic exam within a calendar year.

You must contact your PCP for all care unrelated to OB/GYN care.

IDENTIFICATION CARDS

Q: Do I need an identification card to use Aetna HMO services?

A: Yes. When you participate in the Plan, you and each enrolled member of your family receive an identification card. Your ID card lists the telephone number and tax ID of the Aetna PCP you have chosen. Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

IMPORTANT: ID cards should be presented at each visit to a health center, Physician's office, pharmacy or hospital.

MAKING AN APPOINTMENT

Q: What do I do to see my Primary Care Physician?

A: To be seen in a timely manner, please call your Physician's office number listed on the front of your ID card.

Q: Are there any special reminders I need to know about when making appointments?

A: Yes**.**

1. CALL YOUR PRIMARY PHYSICIAN FIRST.
   If you walk in without an appointment, you may not be able to be seen.
   Depending on the urgency of your situation, a health care professional may call you back to evaluate your appointment needs.
2. HAVE YOUR ID CARD READY.
   When you schedule an appointment, the receptionist may ask for:
   - Your name.
   - Your Member number (the Social Security number of the subscriber).
   - The name of your Primary Care Physician.
   - The purpose of your visit (be specific).
   - A detailed description of symptoms.
   - Your phone number.
3. INITIAL APPOINTMENTS.
   If you are scheduling a first appointment, please let the receptionist know.
4. Arrive 15 MINUTES EARLY FOR YOUR FIRST APPOINTMENT.
5. COPAYMENTS.
   If you are required to pay a copayment, please pay when you arrive at the Physician's office. Refer to the Booklet for medical services that require copayments.

Q: What if I know I'm going to be late or will have to miss an appointment?

A: If you are not able to keep an appointment or if you expect to be late, please call your Physician's office. If you are going to be more than *15 minutes* late, you may be asked to reschedule your appointment. The Plan does not cover canceled office visits or missed appointments.

Q: What if I have to call for something other than scheduling an appointment?

A: If you need medical advice, lab results or other medical information, call the Primary Care Physician's office listed on your ID card. The Primary Care Physician's staff will be able to help you or will have the Physician call you back.

Q: What if my Physician is out of the office?

A: Physicians "cover" for each other on a rotating schedule. This means there may be times when you will not be able to speak with your Primary Care Physician. (For example, when the Primary Care Physician is on vacation.) The Nurse or Physician "on call" will be able to help you.

REFERRALS TO SPECIALISTS

Q: What if I need to see a specialist for medical care my Primary Care Physician can't provide?

A: If you need special medical care your Primary Care Physician cannot provide, you will be referred to a Specialist. Orthopedic Surgeons, Allergists, Cardiologists, and General Surgeons are examples of Specialists. This also applies to services such as Physical Therapy, Home Health Care and Durable Medical Equipment. Your Primary Care Physician will provide or arrange for all of your medical care and will make necessary referrals for you. Remember, Aetna HMO benefits do not cover services or hospitalization unless approved by your Primary Care Physician or network Specialist, and in some cases Aetna HMO's Medical Director. *Refer to the Emergency Cares Section for exceptions.*

You must have a referral to see a Specialist for services to be covered under your Aetna HMO plan.

Q: What if I need a special medical test or treatment?

A: If the test or treatment cannot he performed in your Primary Care Physician's office, a referral will be arranged for you. You may be asked to pay the standard office visit copay listed on your ID card when the test or treatment is rendered. Your Primary Care Physician is able to perform many tests or treatments in the health center or office. It you are only having the tests done in your Primary Care Physician's office, you are not required to pay a copay (for example, if lab work was the only service rendered and a Physician was not seen).

EMERGENCIES

Q: Am I covered in case of a medical emergency?

A: As an Aetna HMO Member, you are covered for medical emergencies that occur when you are in or out of the service area. A medical emergency is a sickness or injury of such a nature that failure to get immediate medical care could put your life in danger or cause serious harm to bodily functions. Some examples of *medical emergencies* include but are not limited to:

- Apparent heart attack.
- Uncontrollable bleeding.
- Sudden loss of consciousness.
- Severe shortness of breath.
- Severe burns.

Some examples of conditions which usually are not considered medical emergencies include but are not limited to**:**

- Colds.
- Nausea.
- Flu.

Q: Am I required to call my Primary Care Physician immediately if I have a medical emergency?

A: In a medical emergency, try to contact your Primary Care Physician before seeking treatment. Otherwise, call (or have someone call) your Primary Care Physician as soon as possible. If you are admitted to a hospital, you must notify your Primary Care Physician as soon as possible. All follow-up care must be accessed through your Primary Care Physician. Refer to the list mentioned previously for examples of Medical Emergencies.

Q: Do I have to pay for emergency care?

A: Yes. For each emergency room visit, you will be required to pay the emergency room copayment printed on your ID card. Present your ID card to the hospital representative when you receive medical care; he/she will contact Aetna to verify your eligibility. If you are admitted, your emergency room copay will be waived.

URGENT CARE

Q: What if I must reach my Primary Care Physician after regular office hours?

A: Most Physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk to a representative from the answering service. Please have your ID card available. The on-call health care professional will need to know your name, ID Number, date of birth, your Primary Care Physician's name and a general description of your urgent medical need. This important information will assist the health care professional in providing you with prompt and courteous service.

COVERAGE AWAY FROM HOME

Q: If I'm out of the service area, what do I do?

A: Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a Member Services representative can take this information over the telephone.

HOSPITALIZATION

Q: What if I have to go to the hospital?

A: All hospital stays that are not medical emergencies must be arranged by your Primary Care Physician prior to your admission. Lab tests that are necessary before surgery should also be arranged by your Primary Care Physician.

Q: Do I get to choose the hospital I go to?

A: The hospital to which you have access is determined by your Primary Care Physician. Please check the Participating Hospitals section of the Provider Directory to see which hospital your Primary Care Physician utilizes. Also, with DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind,

simply go to Aetna's Internet address: **www.aetna.com/docfind**.

Q: What if a Specialist admits me to a hospital?

A: If you have been referred to a Specialist and need to be admitted to a hospital, your Specialist, working with your Primary Care Physician, will arrange your hospital care.

Q: Do I need to request authorization for hospitalization?

A: If your Primary Care Physician, or a Specialist to whom you have been referred, admits you to a hospital, he/she will take care of any required authorization.

CLAIMS

Q: How am I reimbursed for ambulance service?

A: If you require emergency care, expenses will be covered under the plan. If it is not emergency care, ambulance services must be precertified by Aetna by calling Member Services at:

1-877-719-3993

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

In most instances you will not receive a bill. If you happen to receive a bill, send it to the address below:

Aetna
P.O. Box 1125
Blue Bell, PA 19422

Q: How do I submit a claim?

A: Two advantages of being a participant in the Plan are that you submit no claim forms and you should not receive any bills. However, if you should receive a bill for covered services, please send the itemized bill for payment **with your identification number clearly marked** to the address shown on your ID card.

In the following circumstances, the Plan will not pay your bill:

- You receive treatment from a doctor or facility in a non-emergency situation without a prior referral from your PCP, or without appropriate authorization from Aetna when required.
- You receive medical treatment that has not been authorized on your referral (i.e., X-rays or lab work).
- You go directly to an emergency center for treatment in your service area when it is not an emergency (see the definition of "emergency," page 11).
- You receive post-emergency follow-up treatment from a nonparticipating provider without authorization.
- You receive services that are not covered by the Plan. (See "Exclusions and Limitations.")
- You receive non-emergency services from a nonparticipating provider without a prior referral fro5 m your PCP ***and*** the prior approval of Aetna.
- This Plan is not the primary plan. (See "Coordination of Benefits.")

ELIGIBILITY/COVERAGE

Q: What if I am covered by another health care insurance plan?

A: Coordination of Benefits (COB), or the arrangement insurance companies have for covering members with more than one insurer, is extremely important to ensure that no duplication of benefits occurs. If your spouse is employed and also has health care coverage, your spouse should file with his/her insurance company first. In order to coordinate benefits, your spouse must also use the Aetna HMO network and follow the appropriate procedures. Please contact the Aetna HMO Member Services Department at:

1-877-719-3993

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST and let us know of other coverage. See page 26 for more detail.

Q: What is continuation of coverage? Who is eligible?

A: You and your family members are eligible to continue present coverage if your employment ends or if a family member no longer qualifies as a legal dependent as defined by the State Group Insurance Program guidelines. Refer to your State of Tennessee Employee's Handbook for details.

PHARMACY: PRESCRIPTION DRUGS

Q: Are my prescriptions covered?

A: Yes. As an Aetna HMO Member, you may go to any participating Pharmacy (refer to the Pharmacy Directory in your enrollment materials for specific pharmacies). Also, with DocFind® you can conduct an online search for participating doctors, pharmacies, hospitals and other providers. To use DocFind, simply go to Aetna's Internet address: **www.aetna.com/docfind**.

The copayment listed on your ID card will apply for each medication or refill. Prescriptions may be purchased at either the retail level or through the Aetna Rx Home Delivery program. You may obtain up to a 30 days supply from participating pharmacy for one copayment. Or, you may obtain up to a 90-day supply through the new Aetna Rx Home Delivery program for one copayment. Generic drugs may be substituted for brand-name products.

If you have obtained care from a participating physician other than your Primary Care Physician, you should still use your participating pharmacy. Refer to your Pharmacy Directory or contact the Member Services Department at:

1-877-719-3993

Monday through Friday, 8:00 a.m. to 6:00 p.m. EST.

REMEMBER: Taking your medication as prescribed is important. *Do not wait until you run out of your prescription. Call a few days in advance to reorder.* This will also save you waiting time.

Q: What if I can't get to a participating pharmacy?

A: You may receive HMO benefits for prescription drugs from a non-participating pharmacy (such as the

pharmacy department at a grocery store) if:

- A physician orders immediate use of drugs and a participating pharmacy is not open. Please send copies of the prescription receipt to Member Services with an explanation in order to be reimbursed.
- A physician outside of your service area orders prescription drugs in an emergency situation.

Q: What if my physician prescribes drugs when I leave the hospital?

A: When you are discharged from the hospital and your physician writes you a prescription, take it to your participating pharmacy to have it filled.

REMEMBER: Have your prescription filled by a participating pharmacy unless it is an emergency.

Q: Why does Aetna have a Prescription Drug Formulary?

A: Aetna has created a formulary to give you access to quality, affordable medications. The drugs chosen for our formulary have been approved by the FDA as safe and effective.

Drugs that are considered for our formulary are extensively reviewed. Aetna's Pharmacy Quality Advisory Committee (PQAC) and Pharmacy and Therapeutics (P&T) Committee each meet regularly to review drugs that have been approved by the FDA. Practicing pharmacists and physicians who are participating providers in our network serve on the PQAC. This committee reviews available clinical information on the drugs being considered. The PQAC then provides their qualitative comments to the P&T Committee.

Q: What do I do if my prescription is not on the prescription formulary?

A: The prescription for the brand-name drug that is not listed on the formulary is covered, but you will have to pay the highest copay. Ask the pharmacist to contact your physician to see if the prescription can be changed to a drug listed on the formulary.

PHARMACY: Aetna Rx Home Delivery^{SM} Program

Q: Is Home Delivery (Mail Order) Covered?

A: For participants in the Plan who must take a medication regularly or daily to treat a chronic condition such as arthritis, diabetes or heart disease, Aetna Rx Home Delivery program offers an easy way to obtain them through the mail. These medications are delivered right to your door.

You may obtain up 90-day supply of the drug through Aetna Rx Home Delivery, if authorized by your physician.

The minimum quantity dispensed through the program is for a 31-day supply, and the maximum quantity is for a 90-day supply. The copayment shown in the "Summary Schedule of Benefits" will apply to each home delivery purchase.

Q: How do I order my medications through Aetna Rx Home Delivery?

A: Just follow these simple steps to order your covered medications:

1. Ask your doctor for *two* signed prescriptions –
   - one for an initial supply to be filled at your retail pharmacy
   - the second one for an extended supply that you can receive through Aetna Rx Home Delivery once you and your doctor determine that the medication is right for you.
   Please note: In order for Aetna Rx Home Delivery to dispense Schedule II medications in any quantity greater than a 30-day supply, your physician must write a diagnosis on the prescription. Some examples of Schedule II medications are Ritalin, Oxycontin and MS Contin.
2. Print your name, address and health plan member ID number on each prescription.
3. Complete the New Participant Order Form, including the patient profile section, for you and your eligible dependents who will obtain medication from Aetna Rx Home Delivery. (You will not need to complete this form when ordering refills, unless your Patient Profile information has changed.)

Q: When will I get my prescription?

A: Generally your medication will be delivered to you, postage paid, within 14 days. If you submit insufficient information to process your order, or if you or the prescribing physician need to be contacted, delivery could take longer. Medications can be shipped overnight for an additional charge.

Q: How do I order refills?

A: Each time you receive medications by mail, you will receive a prescription receipt that includes a refill date indicating when your prescription can be refilled. You can request a refill after that date. Allow at least 14 days for processing your order.

- Visit www.aetnarxhomedelivery.com, click on Rx refills and complete all of the information requested. You can also track prescription orders through this website; or
- Call Aetna Rx Home Delivery toll-free at **1-866-612-3862**. (TTY **1-800-201-9457**). Provide your health plan member ID number, your prescription number and your credit card number; or
- Fill out the Prescription Drug Order Form you received with your medications and mail you refill request to Aetna Rx Home Delivery.

Most prescriptions, including refills, expire within one year (sometimes sooner) from the date they are written. After the expiration date, you must get a new prescription from your doctor, even if your prescription label still shows refills remaining.

Q: Can I combine my prescription and refills to get more medication at one time?

A: You may only obtain amounts authorized by your physician. For example, if your physician writes your prescription for a 31-day supply with two refills, you may only receive a 31-day supply at a time.

Q: What if I have questions?

A: If you have a question about your medication or the status of your order, or if you want to speak with a pharmacist, call Aetna Rx Home Delivery toll-free at **1-866-612-3862**, Monday through Friday, 7:00 a.m. to 11:00 p.m. EST; Saturday, 8:00 a.m. to 9:30 p.m. EST; and Sunday, 8:00 a.m. to 6:00 p.m. EST. (TTY **1-800-201-9457**).

If you have questions about your pharmacy benefit, please call the Member services number on your ID card.

QUESTIONS/MEMBER SATISFACTION

Q: What if I have a question about any service I have received?

A: If you have questions about Aetna or if you are not satisfied with any service you receive from Aetna or any Aetna participating providers (such as nurses, medical assistants, etc.), please contact the Member Services Department at:

1-877-719-3993

or write to:

Aetna
P.O. Box 1125
Blue Bell, PA 19422

Q: What does medically necessary mean?

A: It means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;

- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when his or her disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

MENTAL HEALTH/COUNSELING SERVICES

Q: Do I need my Primary Care Physician's permission to receive Mental Health counseling services?

A: No. As an Aetna HMO Member, you may seek Mental Health/Counseling services directly. Please call Magellan Behavioral Health at:

1-800-723-5845

24 hours a day, 7 days a week.

Q: Who provides these services?

A: Counseling services are provided by Psychiatrists, Psychologists, Clinical Nurse Specialists and Licensed counselors experienced in treating children, adults and families. These services include:

- Crisis Intervention
- Individual, group and family counseling
- Medication management for nervous disorders.

Free counseling and referral services may be available through the State's Employee Assistance Program.

Call the Employee Assistance Program at 1-877-237-8574 to see if you are eligible for these services.

All services, plans and benefits are subject to and governed by applicable contracts, policies and government regulations. All benefits are subject to coordination of benefits and the terms (including exclusions and limitations) of the Agreement between Aetna Life Insurance Company and the State of Tennessee. The information herein is believed accurate as of publication and is subject to change without notice.

Privacy Notice

Aetna considers member health information private and confidential and has policies and procedures in place to protect such information against unlawful use and disclosure. When necessary for a member's care or treatment, the operation of our health plans, or other related activities, we use member health information internally, share it with our affiliates, and disclose it to providers (doctors, dentists, pharmacies, hospitals and other caregivers), other insurers, third party administrators, payors (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits a member receives under the plan), vendors, consultants, government authorities, and their respective agents. These parties are required to keep the member health information confidential as provided by applicable law. For example, Aetna uses and discloses member health information to administer benefits policies and contracts (which may include activities like claims payment; utilization review and management; medical necessity review; coordination of care, benefits and other services; auditing; anti-fraud activities; and plan-related analysis and reporting); operate preventive health, early detection, and disease and case management programs; perform quality assessment and improvement activities; conduct performance measurement, outcomes assessment, and health claims analysis and reporting; manage our data and information systems; comply with legal or regulatory requirements; conduct litigation and similar proceedings; transition policies and contracts to or from other insurers, HMOs and third party administrators; and facilitate due diligence proceedings in connection with the purchase, sale or transfer of health benefits plans.

To obtain a copy of Aetna notice describing in greater detail the practices concerning use and disclosure of member health information, members can call the toll-free Member Services number on their ID card or visit our internet site at www.aetna.com.

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